COVENTRY
Health Care of Nebraska, Inc.

City of Lincoln At-A-Glance

Welcome to Coventry Health Care of Nebraska!

The City of Lincoln benefit plan allows members to access in network and out of network providers. The highest level of benefits is provided when you access participating providers with Coventry Health Care. There are no referrals needed for specialty care. You are not responsible for filing claims when you use participating providers.

If you choose to receive care by non participating providers, please ask the provider about their billed charges before you receive care. You will be responsible for higher copays, deductibles, coinsurance and amounts exceeding the out of network rate. The amounts could be significant.

If you have questions regarding the City of Lincoln benefits, please contact our Customer Service department at **800-288-3343**. A representative will be able to assist you.

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BENEFITS	MEMBER PAYS	
	In Network Preferred Benefits	**Out-of-Network**
Deductible (Per Calendar Year)		
• Individual	$250	$250
• Family (Aggregate)	$500	$500
Coinsurance (Per Calendar Year)	10%	20%
Out-of-Pocket Maximum: (does not include deductible)		
• Individual	$500	$1,250
• Family (Aggregate)	$1,000	$2,500
Maximum Benefit:	Unlimited	$1,000,000
Physician Office Services: (Family Practice, General Practice, Internal Medicine, Pediatrics)		
• Physician office visits for routine physical, injury, or sickness	$15 Copayment	Deductible & Coinsurance
• Pediatric and Well Child Care including immunizations		
• Diagnostic X-ray and laboratory (in Physician's Office)		
• Physician office visit for routine maternity services		
• Injections		
Specialty Physician Office Services:		
• Specialty Physician office visits for routine physical, injury, or sickness	$15 Copayment	Deductible & Coinsurance
• Diagnostic X-ray and laboratory (in Physician's Office)		
• Specialty Physician office visit for routine maternity services		
• Injections		
Dental Accidental Injury Benefit		
*Prior notification is required before follow-up treatment begins	*Deductible & Coinsurance	*Deductible & Coinsurance
Vision Exam (Every 24 months)	$10 Copayment	Not Covered
Inpatient Hospital Services		
• Unlimited Hospital Days (Semi-Private Room and Board)	Deductible & Coinsurance	*Deductible & Coinsurance
• Private Room and Board when Medically Necessary		
• Professional Services		
• Maternity Care		
• Medications and Drugs		
• X-ray and Laboratory		
• Intensive/Coronary Care		
• Radiation Therapy		
• Administration of Blood		
Transplants		
(When performed at a Coventry Transplant Network Facility approved by CHC)	Deductible & Coinsurance	Not Covered
Reconstructive Procedure		
• Office Visit	$15 Copyment	*Deductible & Coinsurance
• Outpatient/Inpatient	Deductible & Coinsurance	*Deductible & Coinsurance
Outpatient Hospital Services		
• X-ray and Laboratory	Deductible & Coinsurance	*Deductible & Coinsurance
• Ambulatory Surgery		
• Diagnostic Procedures		
• Professional Services		

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Short Term Therapies For maximum benefit coverage all services require prior authorization • Speech, Occupational, Respiratory, and Physical (60 visits per calendar year for combined therapies) • Cardiac Rehabilitation (therapy is covered per calendar year up to 36 visits)	$15 Copayment	*Deductible & Coinsurance
Spinal Treatment 24 visits per calendar year	$15 Copayment per visit	*Deductible & Coinsurance
Diabetes Treatment • Self management training benefit • Supplies, Test Strips, Lancets, Syringes (100% covered when Coventry Provider Used)	$15 Copayment per visit No Charge	$30 Copayment per visit *Deductible & Coinsurance
Nursing Facility For maximum benefit coverage all services require prior authorization Limited to 60 days per calendar year	Deductible & Coinsurance	*Deductible & Coinsurance
Home Health Care For maximum benefit coverage all services require prior authorization Limited to 60 days per calendar year	Deductible & Coinsurance	*Deductible & Coinsurance
Hospice For maximum benefit coverage all services require prior authorization 360 day lifetime maximum	Deductible & Coinsurance	*Deductible & Coinsurance
Prosthetic Devices For maximum benefit coverage all services require prior authorization Limited to $2,500 per calendar year	Deductible & Coinsurance	*Deductible & Coinsurance
Durable Medical Equipment (DME) For maximum benefit coverage all services require prior authorization Limited to $2,500 per calendar year	Deductible & Coinsurance	*Deductible & Coinsurance
Urgent Care Center • At an Urgent Care Facility	$35 Copayment	*Deductible & Coinsurance
Emergency Health Services • Hospital Emergency Room	$100 Copayment	$100 Copayment
• Ambulance Ground transportation Air transportation	Deductible & Coinsurance	*Deductible & Coinsurance
Mental/Nervous/Substance Abuse • Outpatient - Must receive prior authorization from United Behavioral Health (UBH) by calling 866-860-7476. In network and out of network benefits are limited to 20 visits per calendar year. **Serious Mental Illness is covered the same as any other Mental Illness, but is not subject to the annual visit limit maximum.**	$15 Copayment	*Deductible & Coinsurance
• Inpatient - Must receive prior authorization from United Behavioral Health (UBH) by calling 866-860-7476. In network and out of network benefits are limited to 30 visits per calendar year. **Serious Mental Illness is covered the same as any other Mental Illness, but is not subject to the annual visit limit maximum.**	Deductible & Coinsurance	*Deductible & Coinsurance

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Temporomandibular Joint Disorder (TMJ) Benefits are subject to a maximum policy benefit of $2,500. Prior authorization is required.		
• Physician	$15 Copay	*Deducitble & Coinsurance
• Outpatient/Inpatient	Deducitble & Coinsurance	*Deducitble & Coinsurance
Pharmacy		
• Retail 31 day supply	$10 Generic Formulary $25 Brand Formulary $40 Non Formulary	Same as in network benefit when a Coventry National Chain Pharmacy is used.
• Mail Order - 93 day supply	$20 Generic Formulary $50 Brand Formulary $80 Non Formulary	

Note: Flat dollar copays are not subject to the deductible. Failure to request prior authorization when and as required, may result in reduced benefits and in some instances, Benefits may be denied. Out-of-Pocket contributions may also be reduced or denied.

* Services where prior authorization is the covered member's responsibility.

Exclusions & Limitations
Services not covered include: services that are not medically necessary; personal or convenience items; custodial care; cosmetic services and surgery; over-the-counter drugs and medications not requiring a prescription; experimental procedures and treatments; and food or food supplements. For maximum benefit coverage, all services, except in the case of a Medical Emergency and Out-of-Area Urgent Care, should be rendered or authorized by Participating Providers.

Members are required to obtain prior authorization for planned hospital admissions and for elective surgeries. Contact Coventry Health Care of Nebraska, Inc. prior to a hospital admission or elective surgery. A penalty of 20% of the Out-of-Network Rate will apply if you do not prior authorize a planned hospitalization. Penalties do not apply towards the out-of-pocket maximum.

This Schedule is part of Your Evidence of Coverage (EOC) but does not replace it. Many words are defined elsewhere in the EOC and other limitations or exclusions may be listed in other sections of your EOC. Reading this Schedule by itself could give you an inaccurate impression of the terms of Your Coverage. This Schedule must be read with the rest of Your EOC. A complete list of Coverage Services, Exclusions, and Limitations can be found in Your EOC.